FamiliesUSA
The Voice for Health Care Consumers

By email to: MSPP@opm.gov

From: Cheryl Fish-Parcham, Deputy Director of Health Policy, Families USA

Re: Draft application comments, OPM 35-12-R-0006 (model application for multistate plan)

Date: October 22, 2012

In general, we are pleased that this application solicits good information about a plan's past performance, its compliance with state laws, adequacy of the provider network, customer service, quality assurance, and premiums and finances. Following are areas where we have questions and concerns:

1) Information about applicants' proposed benefit package is currently blank pending forthcoming guidance. We recommend that applicants demonstrate the following: (a) At a minimum, plans must meet the EHB standards in the states where they operate. Without such a requirement, these plans may lack coverage for services that all other individual and small group plans in the state cover, causing adverse selection and undercutting important state requirements. (b) If plans have discretion to define their coverage of habilitative services, OPM should evaluate the adequacy of the proposed coverage. (c) OPM should ensure that plans meet mental health parity requirements. (c) As drafted, the plan must submit some information about its prescription drug coverage. Plans should also submit information showing that they have a formulary exceptions process for cases of medical necessity. We hope that forthcoming guidance will require that these plans, as well as all plans offering essential benefits to include prescription drug coverage that is comparable to a typical employer plan. This means that the essential health benefits will require a broad range of drugs covered within each category and class.
2) We concur that applicants must demonstrate that they are licensed in each state and that they comply with state prompt payment laws. Additionally, the application should clarify that multi-state plans must comply with all state laws for the markets in which they are operating, and with processes such as rate filing and review, market conduct examinations, and other oversight activities. Several states are currently moving forward on initiatives to improve quality and reduce costs in health plans, such as by creating medical homes or requiring standardization of medical records or through payment reform. We want to be sure that a multi-state plan complements and does not undermine these efforts. The draft application on page 14 asks for "your proposal for complying with laws, regulations, and rules set forth by a State and/or Exchange regarding the use of agents and brokers for products offered through an Exchange." Please clarify that applicants must comply with laws, regulations, and rules set forth by *both*

states and the applicable exchange. States should be able to take prompt action to stop any marketing activity that is harmful to consumers.

3) OPM should work with states to establish be a clear process for terminating plans that do not abide with state law and regulations and that do not take appropriate corrective action.
4) All exchange plans must offer at least gold and silver level coverage. The application asks the applicant to list whether it is offering each medal tier (platinum, gold, silver, and bronze.) At a minimum, multistate plans should have to offer any medal level tiers that are required by a state exchange.
5) According to proposed guidance on actuarial value, qualified health plans will be submitting their designs to reach required cost-sharing assistance levels, but they may have considerable discretion in those designs. We recommend that the evaluation criteria for multi-state plans include whether the proposed cost-sharing structures provide reasonable access to care for enrollees. We are concerned that high-deductibles might stop many enrollees from getting care that is beyond preventive care. In subsequent years, we recommend that multi-state plans service to enrollees that receive cost-sharing assistance be specifically evaluated: claims data will be a valuable tool to determine whether the cost-sharing assistance is working.
6) In states that have further standardized cost-sharing for qualified health plans, multi-state plans should be required to meet the standards.
7) Multi-state plans should likewise have to comply with any additional criteria that an exchange places on qualified plans. Some states are exploring additional requirements regarding the display of quality-related data. Other states, such as Oregon, are considering limiting the number of plans carriers can offer. Over the long term, state exchanges should have the freedom and flexibility to test and implement new ways to deliver higher value plans to consumers (as Massachusetts has done). However, states will not be able to meaningfully improve exchange plan offerings in their states if multi-state plans are exempt from the requirements.
8) We generally support the proposed approach of using Medicare Advantage standards to determine network adequacy. However, we urge you to supplement this with standards related to pediatric providers, mental health providers in addition to psychiatrists, substance abuse treatment providers, and any other categories of providers that may be needed by the exchange population and are not traditionally used by Medicare Advantage enrollees.
9) The network adequacy approach indicates that in some circumstances, plans may be required to provide in-network rates to certain out-of-network providers. We agree that this is appropriate both in cases where a person must use an out-of-network provider in an emergency, and in cases where there are insufficient in-network providers or a lack of in-network providers with expertise in the enrollee's health condition. In both of these cases, the plan should be required to enter into an agreement with an out-of-network provider that will hold the enrollee harmless for any costs beyond the plan's cost sharing levels for in-network care. This has been an important feature in Medicaid plans, and will likewise be essential to protect exchange enrollees from high costs when they must use an out-of-network provider for a medical reason.
10) Please clarify how consumer complaints will be handled. Ideally, all consumers in the exchanges should be able to get a problem with an exchange health plan addressed by calling just ONE

number, and should not have to determine whether their plan is a multi-state plan in order to identify the proper agency to handle a complaint. Whatever role OPM plays in complaint handling or resolution, it should have a very strong feedback loop with state departments of insurance. These departments often rely on consumer complaints - and the trends they reveal - to conduct effective oversight and enforcement.

11) Any multi-state plans should develop networks to effectively serve rural areas. These areas are often underserved by health plans.

Thank you for considering these comments.

NAIC National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

August 10, 2011

Ms. Cheryl D. Allen
United States Office of Personnel Management
1900 E Street, N.W.
Washington, DC 20415

Re: RFI # OPM35-11-R-0001

Dear Ms. Allen:

Please find attached comments from the National Association of Insurance Commissioners (NAIC) in response to OPM's Request for Information regarding Multi-State Plan Nationwide Insurance Plans Offered through Exchanges. The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

While your Request for Information was addressed mainly to health insurance issuers who may be interested in participating in the program, we believe that OPM would also benefit from the experience and expertise of the state regulators with oversight of these markets. For this reason, we are providing comments to selected questions that we believe will be critical as OPM decides how to implement the Multi-State Plan program. As we have expressed in our comments, Insurance Commissioners and the NAIC have serious concerns about the potential for market disruption and adverse selection, and the resulting negative impact on consumers and health insurance markets, which would arise if Multi-State Plans are allowed to operate under different rules than their competitors.

We stand by to assist in any way possible and look forward to continuing to work with OPM as it moves forward to implement this very difficult provision of the health reform law. Please do not hesitate to contact us if you have any questions or if we can be of any assistance.

Sincerely,

Susan E. Voss
Iowa Commissioner of Insurance
NAIC President

Kevin M. McCarty
Florida Commissioner of Insurance
NAIC President-Elect

James J. Donelon
Louisiana Commissioner of Insurance
NAIC Vice-President

Adam Hamm
North Dakota Insurance Commissioner
NAIC Secretary-Treasurer

Background and Interest

9. What additional issues and advantages do you see with offering a Multi-State Plan?

As the officials charged in each state with protecting consumers of insurance and with promoting healthy and competitive insurance markets, Insurance Commissioners are concerned that the Multi-State Plan program could provide some of the nation's largest insurers with significant market advantages, thereby making it more difficult for other carriers to compete for business within an Exchange.

Multi-State Plans have a built-in competitive advantage because they will be automatically deemed to be certified for sale on Exchanges and, thus, their policies will be offered in every State. As a result, Multi-State Plans have the opportunity to write a significant percentage of the policies offered to individuals and small groups, allowing Multi-State Plans to spread administrative costs over a larger number of lives. This is an inherent advantage for Multi-State Plans. It is important not to exacerbate this built-in advantage by exempting Multi-State Plans from the regulatory oversight of Insurance Commissioners and programmatic oversight by State Exchanges.

Interim regulations issued by the Department of Health and Human Services (HHS) demonstrate States will have wide latitude in operating Exchanges. As states review their markets, each state is likely to identify requirements plans must meet as a condition of certification for the Exchange. These requirements, such as requiring that qualified health plans sold on Exchanges perform additional disclosures, offer plans at the bronze and platinum levels in addition to the already required gold and silver, or offer plans with standardized cost-sharing, could offer significant benefits to consumers and increase the transparency of insurance offered through the Exchange. Unless Multi-State Plans also meet the certification requirements for sale within a state Exchange, the efforts of States to achieve these goals will be frustrated and the carriers competing with Multi-State Plans would be placed at a further competitive disadvantage. We urge OPM to require Multi-State Plans to meet the requirements of certification for each Exchange on which they are sold.

All state Exchanges must be financially self-sustaining by 2015. In order to achieve this, it is expected that states will levy fees and assessments on carriers. If Multi-State Plans are exempt from these fees and assessments, it will be more difficult for Exchanges to be financially self-sustaining and place additional costs on individuals and small employers purchasing coverage from other carriers inside or outside the Exchange, as the premium must be the same for the same policy. We urge OPM to require Multi-State Plans to be subject to all fees and assessments levied by state Exchanges in order to finance their operating expenses. Allowing larger insurers a free-ride at the expense of smaller competitors would damage competition and could endanger the viability of Exchanges.

12. Do certain State laws create opportunities for or barriers to the operation of Multi-State Plans?

Through the NAIC, states have developed a uniform system for solvency regulation. This national system, which is described in further detail in our response to Question 33, is facilitated by the NAIC and will easily allow OPM to defer to state solvency and financial regulation for Multi-State Plans without imposing additional or alternative requirements upon issuers participating in the program.

The NAIC, HHS, and individual states have worked closely together to develop uniformity for external review and rate review for unreasonable rate increases. Exempting Multi-State Plans from such requirements would run counter to this partnership and commitment to put consumer protection first.

But the health care delivery system varies greatly from one state to another and within a state, and these variations give rise to different consumer protection issues. Under PPACA, a health insurance issuer offering a Multi-State plan remains "subject to all requirements of State law not inconsistent with this section." Exempting Multi-State Plans from the additional consumer protections a state has put in place will confuse consumers, leave some consumers with less protection than others and result in an unlevel playing field that could give the largest insurers additional competitive advantages in the marketplace, thereby undermining the goal of the PPACA to create more competition in health insurance markets and strengthen consumer protection.

Network and Quality Measures

18. What would you propose as a network access standard for primary and specialty care physician practices and hospitals? Are there existing models that you prefer?

State regulators have found through experience that no single network access standard can be satisfactorily applied across the entire country. The needs of urban, suburban, and rural areas all are very different and attempting to impose a single standard across all 50 states could leave consumers in some areas without access to critical providers while destroying the ability of insurers in other areas to engage in meaningful negotiations with providers, driving up premiums. If a single standard is applied to Multi-State Plans, while locally-offered plans operate under long-standing state network adequacy rules, one of the two will gain a competitive advantage, causing adverse selection, disruption of the marketplace, and harm to consumers.

HHS recognized this dynamic in its proposed regulations for Health Insurance Exchanges by deferring to state network adequacy standards in order to avoid creating an unlevel playing field within the Exchange. We strongly recommend that OPM follow the lead of HHS and simply require all Multi-State plans to comply with the state network adequacy standards that apply to everyone in the marketplace.

26. What do you foresee would distinguish a Multi-State Plan from a locally-offered plan on the same Exchange?

There should be no distinction between a Multi-State Plan and any other carrier offering coverage in an Exchange. This will ensure competition and allow consumers to evaluate offerings on the basis of price, benefits, and network.

State insurance laws and regulations have been adapted over the years to address the different consumer protection issues that result from differences in health care delivery systems, labor markets, demographics, and consumer preferences between and within states. Exempting Multi-State Plans from any of these consumer protections in a state, or substituting a single national standard for the more tailored approaches taken by the individual states, would leave some consumers with fewer protections than others, confuse them, and result in an unlevel playing field that could give the largest insurers additional competitive advantages in the marketplace, stifling competition in health insurance markets and weakening consumer protection.

In particular, state regulators would be concerned if Multi-State Plans were permitted to make marketing claims that they are "federal-government approved." Such claims would be intended to give the impression that they are held to a higher regulatory standard or have been through extra regulatory review and are, therefore, of higher quality than their locally-issued competitors. Such claims would be viewed by state regulators as misleading, particularly if Multi-State Plans are somehow exempted from state consumer protection, financial, or other regulatory requirements. Most states expressly prohibit advertisements of accident and sickness insurance that, in any way, indicate that they are endorsed by the federal government. In fact, this prohibition is included in the NAIC Advertisement of Accident and Sickness Insurance Model Regulation, Section 14 (B) and (C). This is a critical consumer protection that should not be compromised.

Operations

28. What are the issues you see in meeting State regulatory requirements with all State Exchanges?

Insurers that would be most likely to contract with OPM to offer Multi-State Plans in the Exchanges already offer coverage in many states today and are experienced in meeting the consumer protection requirements of multiple jurisdictions. We do not foresee any barriers to insurers operating on the Exchanges of every state, provided they comply with all requirements that their competitors will be required to meet, preserving a fair and effective regulatory environment to ensure consumer protection appropriate to each state.

Pricing and Reserving

33. How do you currently reserve for products in the individual and small group markets?

Solvency regulation is one of the cornerstones of consumer protection, and state insurance regulators take their responsibility to ensure the financial soundness of licensed insurers very seriously. Over the years, insurance financial regulation has developed into a national system of state regulation, with insurers filing annual and quarterly financial statements with the NAIC detailing all of their assets and liabilities on a national basis and providing state-level detail of their exposure to risk in many areas. These reports are analyzed by the NAIC and distributed to the regulators of each state in which the company does business so that all states have a complete view of the issuer's financial condition.

When an insurer is authorized to operate in multiple states, it does not calculate its reserves on a state-by-state basis. Rather, insurers maintain reserves that reflect the entirety of their business across all states. To this end, states utilize the NAIC Risk-Based Capital (RBC) standard to provide additional security to consumers. The NAIC RBC formula for health insurers takes a holistic view of the company's finances in every line of business and every state in which it operates. For this reason, it takes into account a variety of risks, including:

1. Underwriting risk and insurance risk (the risk that medical care expenditures will exceed premiums collected)
2. Business risk (operating costs, contracts, guaranty funds, etc.)
3. Asset risk – (credit risk, interest risk, market risk, risks borne by affiliates, etc.)

Unpaid claims reserves are held for all individual and small group major medical products. These include reserves for claims that have been incurred but not yet reported to the insurer, claims that have been reported to the insurer but not yet processed, and claims processed by the insurer but not yet paid. Contingent benefit reserves are held for situations where a claim has been incurred during the time coverage is effective, but services are expected to be performed past the termination of coverage. Lawsuit reserves are held for the payment of claims that are pending a legal decision. Contract reserves may be held for some underwritten individual major medical products to account for increases in average claim levels that will not be offset by future rate increases due to the product's rating structure. In calculating its reserves, an insurer will take into account all of its claims exposure, regardless of the state of issue of the policy. For this reason, we would note that reserving is already done on a national basis, even though policies may be issued in many different states. Health insurance companies are also subject to financial examinations about every 5 years, or more frequently if necessary, to ensure they are accurately reporting their financial information. Because of the comprehensive nature of solvency regulation, it would be inappropriate to apply different solvency and reserving requirements to Multi-State Plans. Doing so would cause fragmentation of a carefully developed system that has protected consumers for many years.

In addition, we would caution that a separate provision of PPACA, intended to ensure a level playing field for all plans offered through Health Insurance Exchanges, would specifically exempt all health insurance plans from a series of specified state and federal laws, including solvency and financial requirements, if Multi-State Plans are not subject to them. Creating a separate system of solvency requirements for Multi-State Plans would, therefore, not only place at risk the enrollees of these plans, but could also disrupt the entire system of solvency protections that apply to every health insurance policy sold in the United States.

State regulators and the NAIC take very seriously their responsibility to protect consumers from the financial failure of health insurance companies. Paying premiums has little benefit if the company does not have the funds necessary to reimburse the claims. We therefore strongly caution OPM against any action that would exempt Multi-State Plans from any aspect of solvency regulation.

34. What potential issues do you see in applying the Medical Loss Ratio provisions of Section 2718 of the Public Health Service Act to Multi-State Plans?

State regulators have a number of concerns regarding application of the Medical Loss Ratio (MLR) provisions to Multi-State Plans. The statute is very clear that the MLR is to be based on the entirety of an insurer's business in each market segment (individual, small group and large group) of each state. As such, we recommend that the experience of Multi-State Plans issued by each insurer be reported together with the experience of all other individual or small-group market plans issued by that insurer in each state. This was one of the most heavily discussed issues during the development of the NAIC's recommendations on the medical loss ratio provision and was the subject of many comments as HHS was developing its regulations implementing this provision. Both the NAIC and HHS gave the question of how experience should be aggregated full consideration and determined that state-by-state aggregation of insurer experience best served consumers in the 50 states. Nationally aggregating the experience of Multi-State Plans would be inconsistent with the intent of the statute and subsequent regulations and would allow insurers to mask lower MLRs in some states with higher MLRs in other states, preventing all consumers from benefitting from this provision.

While the statute does give OPM the authority to negotiate a MLR with each issuer, this provision should be interpreted as granting OPM authority to impose contractual terms that are stronger than otherwise applicable standards in the individual and small group markets of a state. These requirements would supplement, not modify or replace, the minimum MLR guaranteed by section 2718 of the Public Health Service Act, and should use the formula used by all other plans to calculate the MLR. This will ensure that consumers comparing Multi-State Plans and locally-issued plans can make valid comparisons and select the plan that offers the best value. If OPM were to require issuers to maintain higher MLRs on their Multi-State Plan business, it would probably not cause significant disruption in the marketplace, so long as issuers also meet existing MLR requirements on their entire experience in each state's individual and small group markets. Allowing a lower MLR, however, could give these larger insurers an additional advantage in the marketplace and should be avoided.

37. Are there any other risks, concerns or recommendations you would like to share?

In addition to what we have noted above, the National Association of Insurance Commissioners would like to offer the following general and additional comments.

Multi-State Plans raise a number of serious concerns for state insurance regulators, which we would like to highlight. These include:

- Creation of an unlevel playing field;
- Potential for risk selection;
- Preemption of state laws for plans that are not Multi-State Plans;
- Increased risk of insolvency; and
- Consumer confusion and difficulty receiving assistance.

Unlevel Playing Field

One of the primary concerns raised by Multi-State Plans is that they have the potential to create an unlevel playing field within Health Insurance Exchanges. If Multi-State Plans are exempted from state consumer protection laws and regulations, such as those governing unfair trade practices, unfair claims practices, network adequacy, external review, marketing, and other areas, plans that are subject to different regulatory standards would be competing against one another in the Health Insurance Exchanges. If the standards imposed upon Multi-State Plans are less stringent than those imposed upon others, Multi-State Plans will benefit from an advantage and will draw business away from those plans that are subject to state laws. This could become particularly problematic if this unlevel playing field creates an opportunity for Multi-State Plans to attract healthier risk or avoid sicker risk than their competitors.

This will be particularly problematic in states that opt to impose additional requirements upon qualified health plans selling coverage through their Health Insurance Exchanges. Because the Multi-State Plans will be "deemed" to be qualified health plans, and thus included on the state Exchange without the state's review of the plan, it

could be difficult for states to require Multi-State Plans to meet the same requirements as all of their competitors unless the OPM contracts require them to do so. This could provide additional market advantages to the Multi-State Plans.

Risk Segmentation

Section 1312(c) of PPACA requires all insurers to "consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool." Similarly, they must also consider all enrollees in small group market plans to be members of a second single risk pool. If federal regulations allow Multi-State Plans to pool risk separately from other policies offered by the same carrier in the individual and small group markets of a state, this provision will have been frustrated and a potential will have been created for Multi-State Plans to separate Exchange business from business sold outside of the Exchange. Insurers could exploit this ability to segment risk by offering predominantly bronze-level plans outside the Exchange, which will likely attract disproportionately healthy enrollees. By maintaining a separate risk pool, insurers would not be required to charge higher premiums to this population in order to subsidize the more heterogeneous risk that the insurer will attract for their Exchange business, where they are required to offer silver and gold level plans that could attract sicker enrollees. This practice would give insurers offering Multi-State Plans a distinct advantage over their smaller competitors that would be required to pool all of their risk together. Such a problem can be avoided by requiring all of an issuer's business in a state market segment to be pooled together, whether that business is sold as a Multi-State Plan or as a locally-issued plan. In addition, Multi-State Plans should also be required to fully participate in the risk adjustment and temporary reinsurance programs that will be administered by each state.

Preemption of State Laws for Other Plans

In order to emphasize that Congress intended for Multi-State Plans and CO-OP Plans to compete on a level playing field with private plans, drafters included a provision that exempted other private plans from 13 categories of state and federal requirements if Multi-State Plans and CO-OP plans were not also subject to them:

- Guaranteed renewal
- Rating
- Preexisting conditions
- Non-discrimination
- Market conduct
- Fraud and abuse
- Solvency and financial requirements
- Quality improvement and reporting
- Prompt payment
- Appeals and grievances
- Privacy and confidentiality
- Licensure
- Benefit plan material or information

It was not Congress' intent to actually create an exemption from these requirements, but to provide extra comfort to the plans that Multi-State Plans and CO-OP Plans would be subject to the same state and federal requirements as every other plan. Indeed, the entire point of the Exchanges is to allow consumers to shop for coverage with the confidence that they are making valid comparisons between plans that are subject to the same regulatory requirements. However, if Multi-State Plans are exempted from any state standards, or held to different standards, it could result in all carriers being exempted from a wide range of state regulatory standards to the immediate detriment of consumers. Such a result would be contrary not only to the letter of the statute, which does require Multi-State Plans to follow state law and regulation, but also to its spirit, purpose, and intent.

Solvency Concerns

As indicated above, at least one of the Multi-State Plans sold on Health Insurance Exchanges in each state must be offered by a not-for-profit entity. There is, however, no nonprofit insurer offering coverage in the commercial market that is currently capable of offering coverage in 51 different jurisdictions. Consequently, the natural alternative for OPM to turn to would be the issuers that offer coverage to federal employees across the country through the FEHBP. Several of these plans are offered by nonprofit entities that theoretically could expand to offer coverage to individuals purchasing through Exchanges in every state and the District of Columbia. These issuers, however, are operating under very different solvency requirements today than commercial carriers follow, and OPM may be tempted to simply extend its current solvency requirements for the FEHBP to Multi-State Plans in order to entice one of the non-profit issuers to participate in the program. Such a step would be very dangerous, both because these standards were developed for a very different marketplace and because FEHBP participants entering the commercial marketplace for the first time will likely face a steep learning curve during their expansion, making appropriate solvency standards all the more important. The result would be a heightened risk of insolvency among these plans and an unlevel playing field on the Exchange.

In addition, state regulators would be very concerned about the potential for insurers to attempt rapid expansion in order to participate in the Multi-State Plan program. This rapid expansion could expose insurers to levels of risk beyond what their capitalization can bear, raising the risk of insolvency at a time when insurance markets are undergoing major changes. In addition, this drive towards rapid expansion could lead to other problems, such as market conduct and other consumer-protection abuses, as state regulators observed when the Medicare Modernization Act of 2003 created the Part D program and expanded the prevalence of Medicare Advantage plans. Observed abuses were particularly prevalent among Medicare Advantage plans rapidly expanding into states in which they had not previously operated and were exacerbated by federal preemptions of state authority over market conduct and consumer protections.

Consumer Confusion and Difficulty Getting Assistance

Finally, exempting Multi-State Plans from requirements that apply to other plans sold through Exchanges could result in confusion among consumers regarding what rights they have with respect to their health insurance coverage and where to go to get help. States have no inherent authority to enforce federal law or regulation, so state insurance regulators would not necessarily have the authority to enforce provisions contained in OPM regulations or contract provisions. If state laws and regulations are preempted, therefore, in order to get assistance, the consumer may have to turn to OPM, rather than receive assistance from his/her home-state insurance regulator, as would ordinarily be the case. Consumers currently look to the states for assistance with their problems. For example, in 2009 states received 322,872 complaints and 2,362,588 inquiries from the public. Preempting those same state regulators from exercising their authority to assist consumers not only creates confusion but substantially reduces protections for those same consumers.